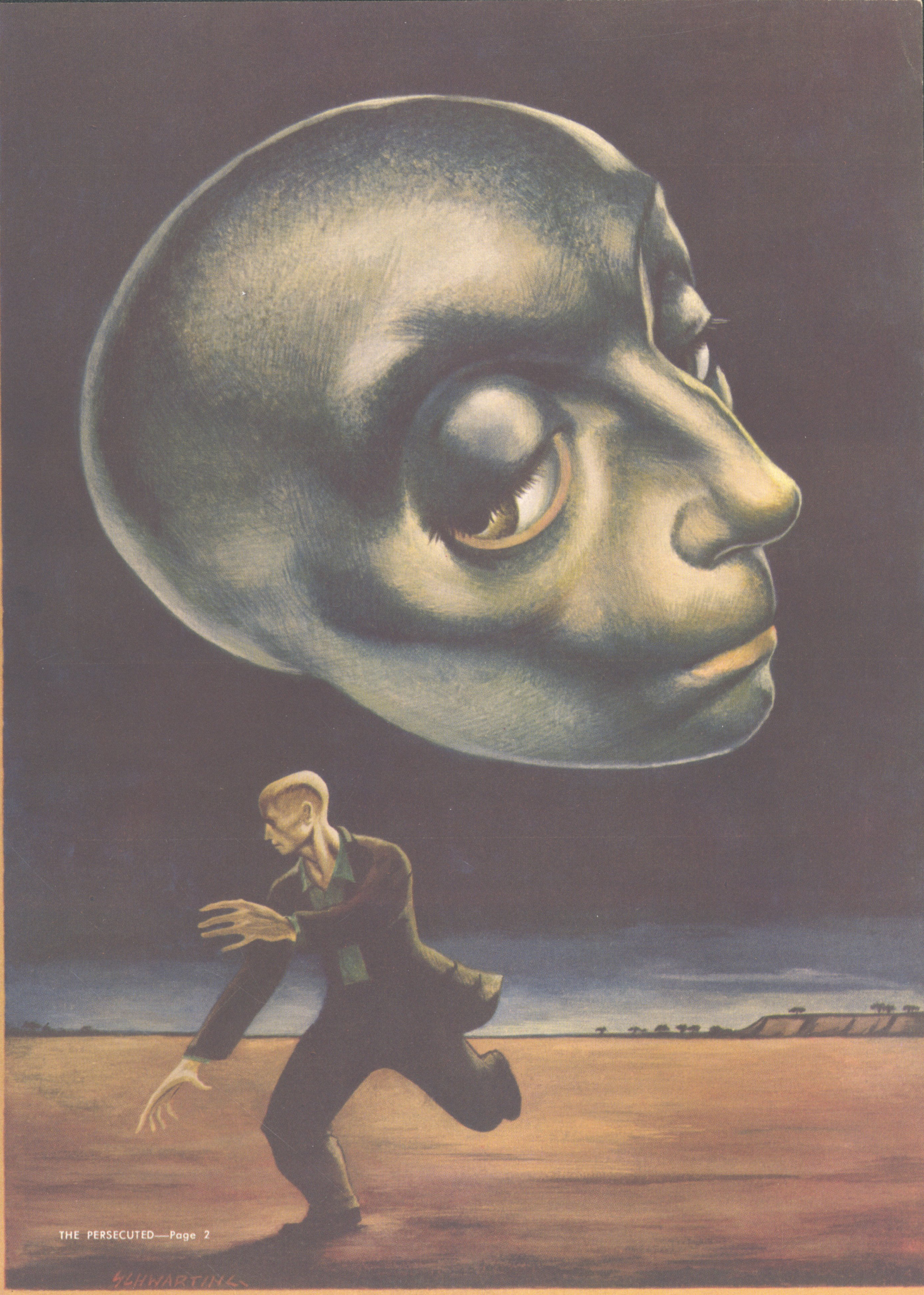
the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE



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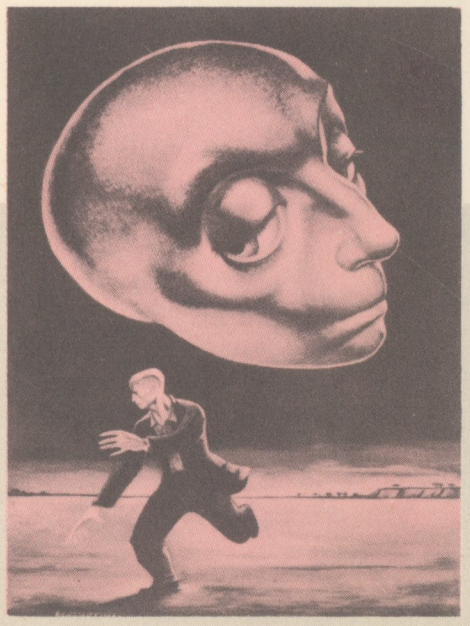

THE COVER

On the cover of this issue is the artist's impression of paranoid reactions. The paranoid individual may be completely normal in all other respects, but is hampered by some stubborn delusion. The delusion frequently suggests that the commonplace features of his surroundings refer to him in some special way, or that certain forces are aligned against him. For a discussion of paranoid thinking, see THE PERSECUTED, page 2.

The painting on the cover was executed by Mr. Joseph F. Schwarting.

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THE PSYCHIATRIC BULLETIN

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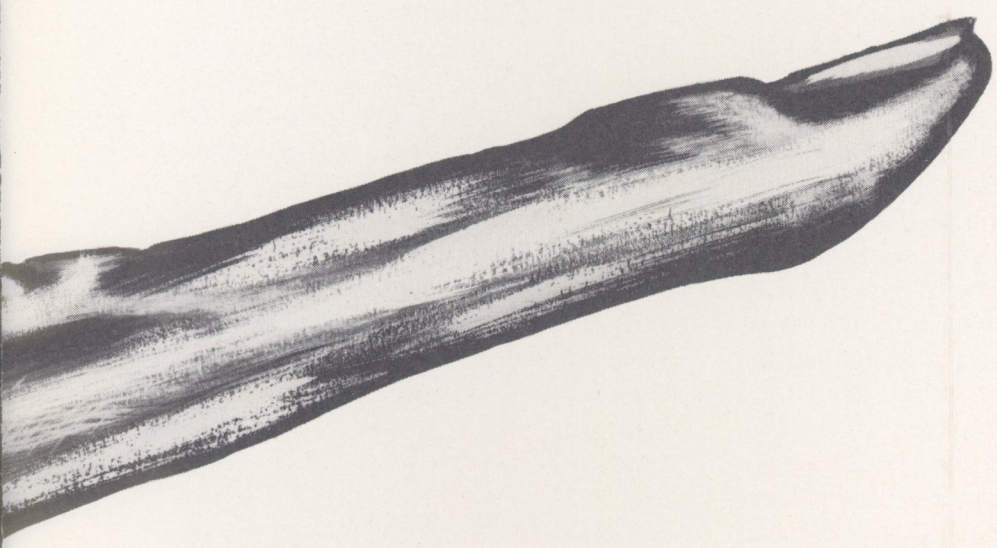

At times—too many times—a vengeful murder dominates the headlines. Perhaps the victim never harmed the killer. There may be several victims who did not even know the killer. Frequently, the murderer makes no attempt to hide his identity. For he feels that his action was entirely justified.

In reading of such an occurrence, the average person reacts by thinking, "The man was surely insane; whatever prompted the authorities to leave him running about loose?" This is indeed an easy question to ask—afterward. But the logic of the paranoid killer can be so air-tight, his intellect so superlative, and his reasoning so sound, that the isolated subject about which his delusions revolve may escape notice by "the authorities" until it is too late.

When questioned, such a murderer will frequently protest, "They should not hound me that way," or "she cannot do this to me." Inasmuch as there is no justification for the impression that he has been injured, yet the killer firmly believes that he has, one is impelled to inquire how such erroneous ideas of persecution originate. The production of paranoid ideas comes about through the mechanism of projection, which is one of the commonplace defenses of the mind. It produces an extensive range of reactions, varying from fleeting and innocuous suspicions to a framework of delusional belief supported by all the logic available to a superior reasoning intellect.

A discussion of paranoid reactions, therefore, presents much the same problem as a discussion of fever. Both are found in a wide variety of conditions which may be either mild or grave. Like fevers, paranoid reactions point to some pathological process but are not, of themselves, specifically diagnostic.

Projection As a Mechanism of Defense

The human organism constantly defends itself against pain, both physical and emotional. Just as the muscle guard of an acutely inflamed abdomen tends to reduce physical pain, so certain mechanisms of the mind operate to reduce emotional pain, to preserve self-esteem, and to insure a sense of security. That part of the mind which mediates between the individual's impulses and the demands of external reality, controls these mechanisms. This part of the mind is referred to as the ego.

Everyone has many conscious inclinations which, if unreservedly gratified, would lead to social catastrophe. By means of the ego, these inclinations are modified, restrained, postponed or directed into modes of expression harmonious with the demands of the environment.

In addition to his conscious inclinations, everyone also possesses certain unconscious wishes and ideas which would pain or frighten him if they broke into consciousness. It is a function of the ego to master the dangerous or painful wherever they originate and harmonize the internal emotional world with the external world of reality. The ego deals with the unconscious through a variety of defense mechanisms. Some of these defenses are successful, in that they manage to ward off internal threats effectively and decisively so they do not recur. One of the more successful defense mechanisms is sublimation. An example is seen in the direction of undesirable aggressive impulses into desirable channels by "tearing into" one's chosen work. In unsuccessful defenses, the emotional energies are not transformed into activities acceptable to both the individual and society. Therefore, the warding off process must be repeated in order to keep the undesirable impulse from erupting into consciousness. Among the unsuccessful defenses is the mechanism of projection.

In projection, the ego finds it easier to cope with *external* dangers than to acknowledge *its own* inacceptable feelings. It therefore attributes to something or someone *else* unwelcome qualities or motives which actually arise from within. Through projection, responsibility is shifted to the outside. Thus, anxiety is relieved and self-esteem is maintained. The individual may really feel "I hate him." But this hostile idea is not acceptable, so the ego projects its own feeling onto the other person and comes to believe instead that "he hates me." It is an easy transition for the mind so deluded to elaborate, "he persecutes me."

Persons with paranoid tendencies are hypersensitive to criticism. Yet, they have no difficulty in finding a logical basis for their ideas. They select some grain of truth which is then greatly exaggerated and distorted, enabling them to rationalize the projection of their own unwelcome emotions.*

Projection in the "Normal" Individual

In assessing the relative importance of paranoid ideas in an individual, the extent to which projection is used is significant. Normal people use it occasionally. Everyone has moments in which he unjustifiably feels disliked or feels that his failure is the fault of another. Feelings of guilt are denied and feelings of inferiority warded off by accusations against others. A lack of self-respect can be projected outward and felt as derogatory attitudes of others toward oneself. But the normal person may discern his own unreasonableness or at least recognize certain distortions of his own making when they are pointed out by someone else. The individual who is emotionally stable enough to be considered normal is not obliged to fall back habitually on projective reasoning.

The less stable an individual is, the more frequently he is apt to meet troublesome situations with some type of unconscious defense mechanism. A neurotic has more need for such defenses than does the normal person. And when he employs them, the neurotic is more resistant to insight, not only through self-observation, but also through the observation of others. The particular defense mechanism unconsciously selected is strongly influenced by the personality make-up of the individual. As would be expected, projection is particularly characteristic among persons of an oversensitive and suspicious temperament. This type of person is referred to in psychiatry as the *paranoid personality*. Its pathological character traits may remain static at this level, but it provides a fertile field for further disruption of the personality into various psychotic manifestations of a paranoid nature.

Paranoia

The psychotic is virtually unable to comprehend his own morbid subjectivity. Anyone attempting to point this out directly is likely to find himself classed as one of the persecutors. Projection with its resulting paranoid ideas reaches its purest and most intellectualized form in true paranoia. This disorder usually has its onset between the ages of 30 and 40. The predominant feature of the disorder is the patient's inability to adapt his dominant ideas to reality. The break with reality is confined to one area. Delusions fill in this gap, but even in the delusional area the thinking is clear, logical and orderly. No hallucinations are present. The patient merely believes something which is not true. The rest of his thinking is subordinated to this false belief. The paranoid patient's emotional reactions are totally in keeping with his beliefs. Feeling that an injustice is being done him, he becomes self-righteously indignant when his delusions are discussed. Since his reasoning is so plausible, he is

* *For an illustration of psychological testing to demonstrate projection, see Questions and Answers, page 19.*

frequently able to convince others that his claims are true. Indeed, if the initial premises could be granted, the remainder of his ideas would seem neither odd nor unusual.

The content of the delusional material determines the form taken by the psychosis. Sometimes delusions of persecution are coupled with delusions of grandeur, and the *exalted* type of paranoia prevails. It is not uncommon for such a patient to claim that his superior accomplishments have gone unrecognized. Grandiose religious beliefs are characteristic, with some patients actually believing that they are on intimate terms with The Almighty.

Occasionally, paranoid delusions take an *erotic* form and the patient is convinced that someone (frequently a person of wealth or prestige) has sexual designs on him. While such beliefs may represent nothing more than wishful thinking on the part of the patient, he is unconscious of this, and his accusations can be extremely troublesome to all concerned.

More common than either of the above two types is the *litigious* paranoiac, who engages in repeated legal action in an effort to establish his claims of injustice. Continued defeat at the hands of the courts strengthens his grievance and brings forth new controversy. Strecker, Ebaugh and Ewalt report a case of paranoia in which the patient was a successful businessman, who held a responsible position with a trust company for 15 years, rising to the position of assistant secretary. His delusion centered around the belief that a wealthy friend had established a trust for him with this firm, but that officials of the company had conspired to deprive him of this inheritance. He met the objections to his contentions with such logic and dignity that a medical student studying the case was prompted to ask on what basis the man could be committed to a mental hospital. This is an example of pure paranoia. In this form it is relatively uncommon, comprising only about 1.9 per cent of the admissions to state mental hospitals in a year. Bonner, however, points out that while commitments are infrequent, any psychiatric disorder in which the personality and the logic remain intact may go unrecognized for years. The delusional framework continues to be built up and elaborated, becoming more logical and systematized as time goes by.

Paranoid Schizophrenia

There is often a strong paranoid coloring in schizophrenia. But *paranoid schizophrenia* presents a different clinical picture from true paranoia. Hallucinations are commonly encountered, the patient complaining that he hears voices accusing him of "evil things". The break with reality is many-sided, and the patient feels that he is victimized by many forces rather than one. The paranoid schizophrenic lacks the consistency of thought of the true paranoiac. While asserting that his wife is poisoning him, he may ask her for a cup of coffee. Whereas the true paranoiac lives in a state of chronic resentment and struggles constantly to overcome his adversaries, the paranoid schrizophrenic is characterized by volatile flights of hatred and easily gives up the struggle for self-justification. His delusions are bizarre, rather than logical, and tend to change rapidly in content. His emotions are not appropriate to his delusional beliefs. Blueler, reporting delusions of grandeur in schizophrenics, noted, "None of our generals has ever attempted to act in accordance with his imaginary rank and station."

Paranoid Symptoms in Other Disorders

Intermediate between paranoia and paranoid schizophrenia are the *paranoid states*. In these states, the break with reality includes more areas than it does in paranoia, yet total personality disintegration does not take place as it does in schizophrenia. In general, the delusional system is more extravagant than in paranoia, but it still retains some vestiges of logic. Many eccentrics, pseudo-reformers, and "cranks" fall into this group.

Paranoid ideas also appear in other disorders. The deaf, particularly those who are proud and sensitive, may give way to unfounded suspiciousness. Alcoholics are prone to develop paranoid reactions of varying intensity. Often alcoholism is accompanied by remorse and self-contempt and the patient makes use of projection to rid himself of these feelings.

Toxic reactions, depressions, organic psychoses—in short, any disturbed states of mind—may reveal intermittent paranoid characteristics. Whatever the accompanying disorder, when severe paranoid symptoms occur, the patient is in need of psychiatric evaluation.

The Physician and the Paranoid Patient

Sometimes the first evidence that a person's thinking is developing along paranoid lines is noted by the family physician. If the paranoid coloring of his thinking is excessive, the individual may be potentially dangerous. The patient who complains of hypochondriacal symptoms and then goes on to explain that other persons are upsetting the inner

Please turn to page 24

Joe is an amputee.

About two years ago the car in which he was riding crashed into an oncoming truck. The head-on collision so severely injured his leg that amputation was necessary. Barely a fifth of his left leg remains.

For the first few days after his operation, Joe lay motionless in bed, staring at the ceiling, speaking only when spoken to. The nurse reported that he apparently maintained complete indifference toward his loss. Although he was silently cooperative, he refused to look at the "thing" that once was his leg.

Joe was *not* indifferent. He was suffering emotionally as well as physically from a deep personal loss. A part of him had been permanently and irrevocably lost. His thoughts ran wild, all of them confused and depressing. He thought, whom do I know who has lost a leg? How will I look? Will I ever walk again? Will my wife still love me? Why do my toes cramp when I know they're not there? Now the doctor thinks I'm "psycho", because he told me that the house psychiatrist is coming by to see me.

Joe was not "psycho", but he had a psychological problem, which, left unrecognized, could have been more disabling than his amputation.

The human mind is capable of withstanding great shock, but rarely are its resources so strong that it can withstand bodily disfigurement without serious reaction. Every person has a mental conception of his bodily configuration, his "body image." It takes time to change this concept. Inability or refusal to accept alteration of this body image and its implications gradually must be overcome, or rehabilitation may be seriously impeded.

The psychiatrist recognizes several major reactions to traumatic personal injuries. The patient may become apathetic, or he may protest or deny his situation. He may cry with fear, or become hostile and blame his fate on others. He may accept the deformity stoically as some deserved punishment, or he may accept the

the PHANTOM limb

situation with good spirits only to demonstrate later an inability to believe it. In some isolated instances, this pseudo-cheerfulness may be what psychiatrists refer to as reaction formation—a defense mechanism against depression. In others, the cheerfulness may be genuine, because the person exults in his very survival, or because he unconsciously welcomes the prospect of profiting from his disability.

The Problem of the Phantom Limb

During the first interview, Joe was unresponsive. When he was asked about his leg, he said it was all right. Although he suffered the sensations of a phantom limb, at the same time he feared the sensation as an indication of insanity. He was afraid to credit his own senses, and since there was no acute pain, he refused to talk about it.

On his second visit, the psychiatrist asked Joe if he experienced any pain. He replied that he did not. Then he was asked whether he felt any sensation at all that seemed to originate in his lost limb. Joe was surprised at the question but reluctantly admitted that sometimes he felt as though his toes were cramping. The psychiatrist told him that all amputees experienced the sensation of a phantom limb for a time.

He related the history of one woman patient, who complained of phantom sensations which sometimes were painful. This patient had an amputation in early childhood. The phantom sensations persisted into middle age. "It is interesting to note," stated the investigator who reported the case, "that there had been two episodes of pain, one at about the age of 20 when the individual was having considerable emotional and economic difficulty. The pain then subsided with the solution of her economic and social problem. The pain recurred at the age of 37 years, three years prior to consultation with the physician, and the pain occurred in a setting of great difficulty in adjusting to a rather difficult marital situation."

The psychiatrist went on to explain that people who are born with absence of a limb do not suffer from phantom sensation, since the body image of these congenitally afflicted individuals does not include the missing limb.

Discussion of the situation and the discovery that his reaction was a normal experience gave Joe reassurance and stability, which he badly needed. After this interview, he complained less about the cramping sensation and it gradually disappeared. He summoned the courage to look at the stump for the first time, while the surgeon was cleaning and dressing it.

Phantom limbs are not always painful. Some believe that the psychologic basis for phantom limb pain lies in the pathologic stimuli from nerve endings in the stump. The pain usually disappears after a time. However, it may become fixed through higher brain centers, where it receives its emotional character. True organic pain is induced by many causes such as neuromata and other pathologic conditions.

The sensation of phantom limb involves deep emotional responses. Loss of a limb is disturbing because of loss of self-esteem from the mutilation as well as loss of function. In addition to this it arouses feelings of real sadness and mourning for the lost member. Aside from the body image as a whole, each part of his body has a strong emotional significance for each person. The emotional disturbance is deepened by memories of such individual landmarks as scars, wrinkles, color and texture of skin, which are recalled in poignant detail. It is natural for

the patient to wonder what became of the amputated part. The patient feels pity and protectiveness toward the familiar member and does not want to feel that something so valuable to him has been cast aside as worthless. Only highly neurotic persons, of course, feel the need for complicated ritualistic burial of a lost extremity.

The phantom limb may represent an emotional response of the patient in which the lost limb has significance to him in terms of his relationships with others. In some patients the symptoms are related to some cause of anxiety in their personal lives. An example of this is seen in the history of one amputee. The patient, a young boy, had overemphasized athletic interest to compensate for feelings of physical inferiority in competition with an athletically accomplished father. Amputation intensified his feelings of inferiority which in turn resulted in tendencies toward dependence. The complaint of pain reinforced this dependence.

After fitting of prosthesis, the sensation of phantom limb may be projected to the artificial limb. Usually, the sensation disappears. Complaints of pain, however, once peripheral causes are ruled out, are interpreted as possible indication of emotional disturbance. In emotionally unstable individuals, the pain tends to come and go with conditions of stress, no matter what type of external treatment is used.

Evaluation of the Patient's Personality Is Important

Often the patient is able to confide in his personal physician better than in a psychiatrist. Certain patients require more specialized attention than others. When it is available, attention by a psychiatric service in the hospital may be most effective. The presence or absence of emotional obstacles depends largely upon the patient's previous personality. In those instances in which there is time to brief the patient before amputation, it is possible to fortify him somewhat against postoperative panic and other psychologic complications. But when preoperative preparation is not possible, psychological assessment will tell much regarding the emotional stability, motivation, skills and interest of the patient. Such evaluation is also useful in advising relatives and employers what to expect in terms of the patient's assets and liabilities.

Returning to the case of Joe, the psychiatrist discovered many facts that were to facilitate Joe's rehabilitation. After his mind was relieved of worries concerning the phantom limb, the question which distressed him most was whether he would be able to get a job. His former employment as a gymnasium instructor was out of the question. It was apparent that, since he could not return to his former job, Joe had to be trained for another one.

The Amputee Must Be Rendered Self-Supporting

Knowing that extended care in hospitals or convalescent centers leads to feelings of depression and dependency, the psychiatrist felt that vocational training for Joe should be embarked on as soon as possible. He contacted the local vocational rehabilitation counselor. Following a thorough investigation and physical examination, funds were authorized for Joe to enter the training center. Here, he was given extensive physical training. He was taught to become proficient in the use of his prosthesis. Personality and vocational evaluation revealed that he had both interest and aptitude in radio work. After nine months he became a certified radio technician and opened his own shop. Joe was again self-supporting.

Not every amputee is as fortunate as Joe. World War II produced about 18,000 amputees, while during the same period, automobile and industrial accidents and disease produced about 120,000 civilian amputees. Many of these patients come to rehabilitation centers only after struggling for many years against physical handicaps. Much of this time lapse results from lack of information about the facilities available in every American community.

It is the policy of rehabilitation agencies to depend upon the family physician to integrate the process of rehabilitation. Physical restoration is authorized *only upon medical prescription.* Furthermore, the physician offers assistance to the rehabilitation workers in the interpretation of medical data and the individual physical possibilities in each case. Through his examination the physician can uncover accessory disorders —unsuspected cancer, latent tuberculosis—which, if overlooked, would entail a waste of rehabilitation efforts and could even cost the patient's life. A detailed clarification of physical status and an appraisal of working ability is necessary in order to train and place the patient on a job. Without the cooperation and liaison of the patient's physician, this integrated service may fall short of the objective of complete restoration. Rehabilitation should be a continuous process, ending with sufficient recovery of function to resume the former occupation or to be trained for another.

Strictly speaking, rehabilitation begins with the choice of amputation site, with the surgeon bearing in mind the necessity of fitting a prosthesis. The physician probably knows better than anyone else how the disability will affect his patient's personality and how reconditioning can best restore his facilities.

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DOROTHEA DIX

In 1843, when the militant little Boston school teacher, Dorothea Lynde Dix, began her work in behalf of the mentally ill, there were only 13 institutions in America to care for them. When she retired, there were 123. All of them had been influenced by her concept of mental illness and, of the 75 state institutions, Miss Dix was personally responsible for the founding of 32.

Dorothea Dix was 40 years old when she undertook the career of self-appointed ambassador in behalf of the mentally ill. She pursued this career until the age of 80.

Calling at the Cambridge House of Correction to teach Sunday School, she found criminals, prostitutes, mental defectives and the mentally ill confined indiscriminately. Some were denied warmth in winter because the open stoves in common use were hazardous within reach of mental patients. The neglect and abuse of these helpless people shocked Miss Dix into action.

The purpose of imprisonment, she reasoned, was reform. The mentally ill did not belong in jails. They were innocent people who merited humane care. Miss Dix believed that it was the duty of the State to provide it for them. The purpose of a mental institution should be the restoration of health. From the beginning of her interest in this work, the founding of state-supported mental hospitals was her primary aim.

The concept that insanity was a form of mental illness was not new even then. It had been demonstrated

in France by Pinel: in America, too, a voice was sometimes raised demanding that chains be struck from the mentally ill. The deplorable facts which Pinel had revealed in France, Dorothea Dix resolved to expose to the world.

In this undertaking she recognized that an aroused public opinion would be her strongest weapon. She went to Dr. Samuel Gridley Howe, who was already well known for his work among defective children. Dr. Howe agreed to present her findings in a letter to the press. If Miss Dix had been shocked at the conditions within the jails, she was outraged at the public's first reaction to her findings. Not until the orator Charles Sumner came forward to substantiate her claims did the public cease calling them slanderous and untrue.

From her initial rebuff, Dorothea Dix learned to work methodically. Consulting often with Sumner, Howe, and Horace Mann, she developed a procedure in Massachusetts which was subsequently duplicated in each of the 48 states and many foreign countries.

During the next two years, she visited every jail, almshouse, and mental hospital in Massachusetts, taking copious notes, and carefully documenting her findings.

Miss Dix wielded a graphic pen. It was not necessary for her to exaggerate. Although Massachusetts had taken steps to provide hospitalization, the facilities were inadequate, and practices were appalling. Violent mental cases were thrown into jail and bound in chains. Often they were poorly fed and given no warmth in winter, since many of their custodians actually believed that psychotic individuals were insensitive to pain. It was a common occurrence for her to find inmates with frozen extremities which resulted in amputation.

She described the plight of hundreds of Massachusetts citizens she had found tied up in barns, outhouses, basements and bins. In her report to the Legislature, she wrote indignantly, "Human beings being reduced to degradation cannot adorn a polished page."

When her report was finished, a Bill was introduced by Dr. Howe to provide additional mental hospital facilities throughout the State. The Bill passed, and Dorothea Dix had won the first of her many legislative victories.

She moved on in rapid order to New York, Rhode Island, and Connecticut. By 1847, she had travelled 30,000 miles, using the most primitive forms of conveyance—oxcart, river boat, and wagon. Within five years, she made periodic inspections of 18 state penitentiaries, 300 jails, and 500 poorhouses.

Upon the founding of the New Jersey State Hospital in 1848, Miss Dix became recognized as a hospital builder as well as a reformer. This was the first great institution to be erected entirely through efforts she initiated.

Miss Dix was a skilled lobbyist. In 1854, she caused both houses of the United States Congress to pass a Public Lands Bill, setting aside 12 million acres of the public domain for the benefit of handicapped persons and the mentally ill. Had it not been for the veto of President Pierce, a permanent grant for this purpose would have become a reality.

Following her conquest of America, Miss Dix carried on her work overseas. In England, she lived for a time as a guest of the Tukes. In

A method of restraining mental patients in the 19th century. *Copyright "Ciba Symposia".*

The unexpected cold shower was measure for calming mental patie

Scotland, where humane treatment of psychotics was thwarted by local officials, she forced the appointment of an investigating commission. At her urging, the lunacy laws were amended and three new public institutions were founded. Her methods abroad were as unorthodox as they had been at home. Sometimes she would arrive unannounced to gain audience with the Lord Advocate, the Home Secretary, or the physician to Queen Victoria. Indeed, Daniel Hack Tuke labeled her "that terrible reformer, but gentle lady."

At the Vatican, she was equally forceful. She made a careful inspection of asylums in the Holy City. Confronting the Pope, she informed him that conditions were "a disgrace and a scandal." Taken aback by her revelations, he made a personal inspection and learned she had spoken the truth. When this Protestant American woman departed from Rome, the Pope called her "a modern St. Theresa."

When she returned from Europe, America was on the verge of the Civil War. Despite her lifelong work in behalf of the mentally ill, Dorothea Dix is generally known today as the first Superintendent of Army Nurses. In 1860, female nurses were a subject of controversy. But Miss Dix had long advocated special nurses' training. Her years of experience with parliaments, politicians, and prison officials left her intimidated by none. She was the logical choice to head an army of untrained women nurses. She began the job with her customary directness. "No woman under 30 need apply," stated her first bulletin. One of the volunteer nurses, Louisa Mae Alcott, described Miss Dix, as "a kind old soul, but very queer and arbitrary."

This "kind old soul" was destined for another 15 years of activity after the war. She resumed her tours of inspection, consolidating the gains she had made for the mentally ill. She never temporized; lost none of her directness. "To have Miss Dix suddenly arrive at your asylum and find anything amiss or neglected," wrote Dr. Isaac Ray, "was considerably worse than an earthquake."

A driving force enabled this fragile woman to travel more miles than any American woman of her day and to become one of the great hospital builders of all time. Miss Dix recognized the compensatory nature of this force. Before fleeing to her grandmother at the age of 12, she had spent a miserable childhood, living with unstable parents in the primitive Maine woods. As a young woman she fell in love with her cousin, who married someone else. She was well on the way to becoming an invalid at the age of 35. But somehow in the process of maturing, Dorothea Dix sublimated her own misfortune in championing those less fortunate than she. Disclaiming any philanthropic motives, she wrote, "I have no particular love for my species at large, but own to an exhaustless fund of compassion."

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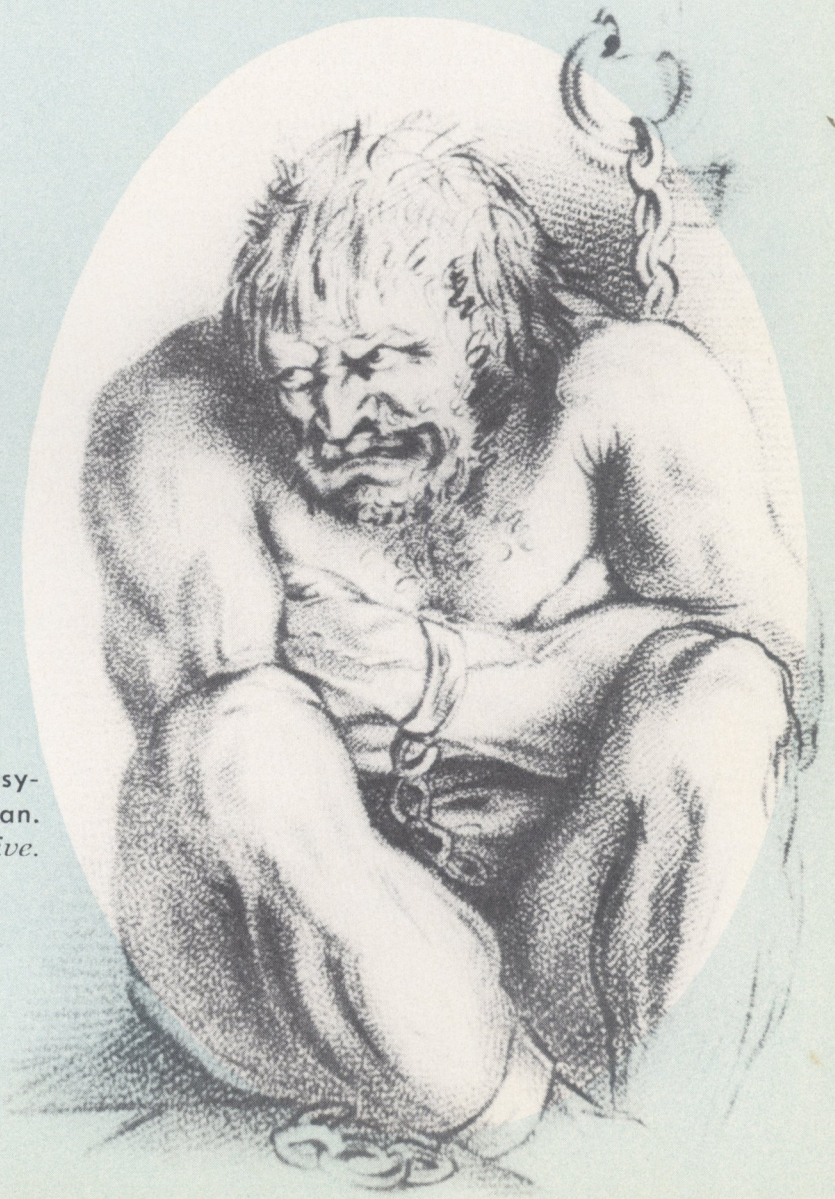
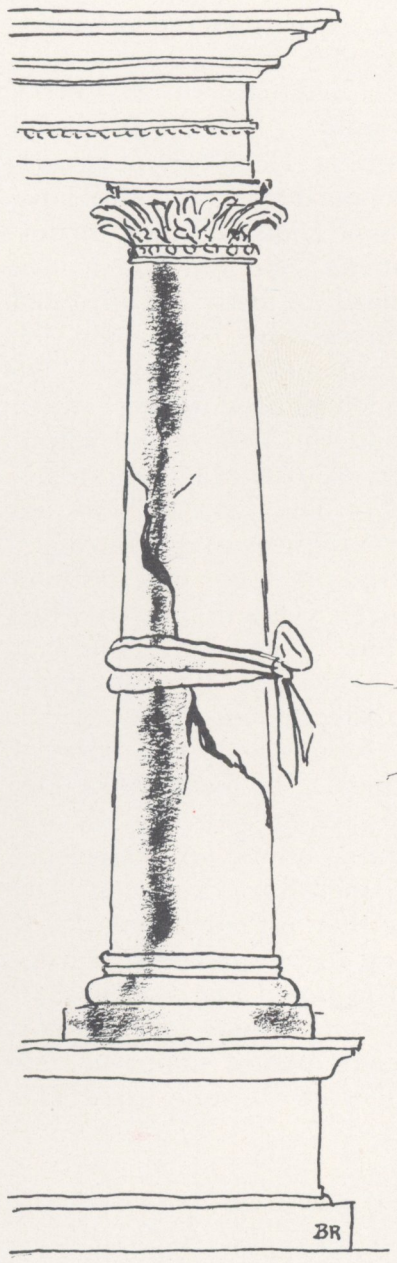
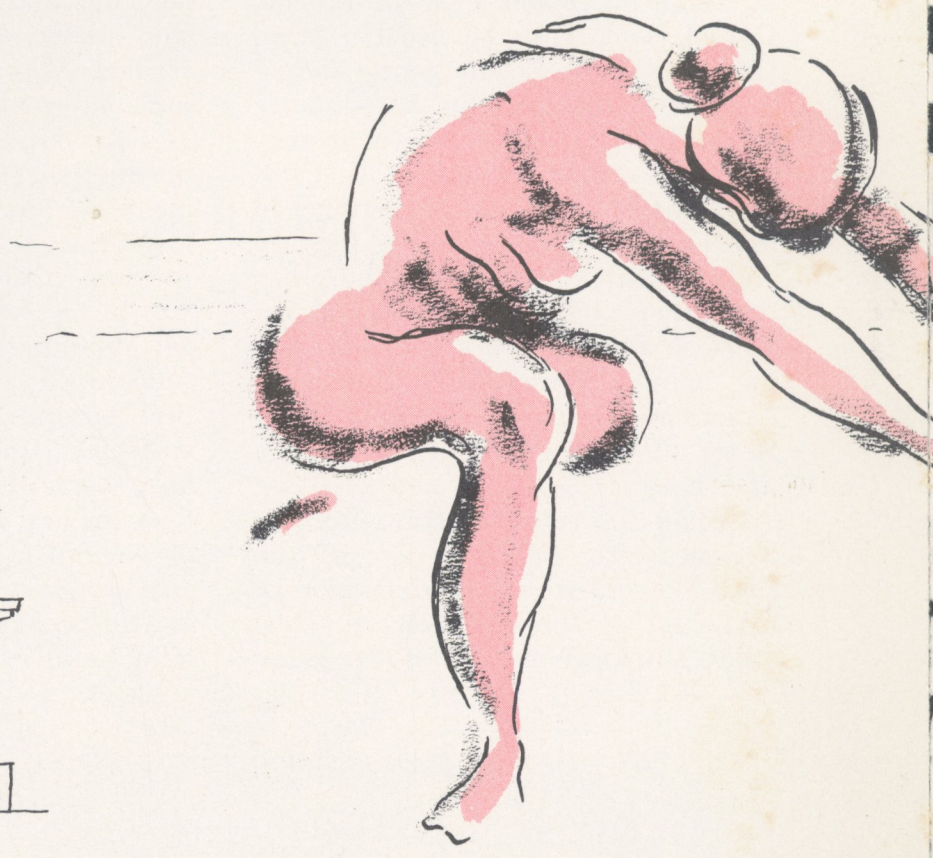


Age-old concept portrays psychotic more beast than man. *Courtesy The Bettmann Archive.*





CASE HISTORY

THE PATIENT, a forty-year-old woman, was referred for psychiatric evaluation following a suicidal attempt by poisoning. The attempt appears to have been a sincere one, but she was apprehended and her stomach lavaged; no serious consequences resulted.

MEDICAL HISTORY: The history reveals that for ten years preceding her presentation for psychiatric examination, the patient had suffered severe abdominal cramps and recurring headaches, both of sufficient severity to require occasional sedation. As a result, she became a chronic user of barbiturates and paregoric. Her dietary history revealed that she was accustomed to going long periods of time without any food except an occasional sandwich and large quantities of coffee.

In the weeks prior to her referral, there was an additional complaint of burning about the feet and legs, and some twitching in the muscles of all four extremities. The symptoms in her feet and legs had a rather indefinite onset, having started with numbness and tingling and progressed steadily in severity. Following her suicidal attempt, these sensations became so acute that the patient could not stand to have towels or clothing touch her feet.

PHYSICAL STATUS: Physical examination revealed no serious variations from the normal. Neurological tests showed some decrease in muscle strength in the lower extremities, but no actual paralysis. The cutaneous response showed a tremendous hyperesthesia over the feet, ankles and legs. Tendon reflexes in the lower limbs were difficult to elicit. The muscles in the calves were quite painful on deep palpation. The remainder of the neurological findings were normal.

PSYCHIATRIC HISTORY: The history revealed that the patient had been married for many years to a reasonably prosperous man, and their relationship had been satisfactory until about ten years prior to her attempted suicide. Throughout these years the patient had been cared for by the family physician. However, both the patient and her husband had consistently refused to divulge to him the significant material. With the precipitation of the situation into a crisis which threatened her survival, both the patient and her husband decided to confide in the psychiatrist, who had the advantage of being an outsider and a stranger in their lives.

The patient had been suffering for years from more or less chronic depressive symptoms which became increasingly worse. About ten years prior to the initial psychiatric examination, the patient had fallen in love with a local citizen, with whom she had embarked on an intermittent extramarital affair. This behavior was accompanied by strenuous feelings of guilt. During her periods of greatest apprehension and guilt, she

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would develop the abdominal cramps, or severe headaches, and would then take large doses of barbital or paregoric for relief of symptoms. She experienced difficulty in eating and began to lose weight. She became preoccupied with the thought that she might have a brain tumor, since two members of her family had died with this affliction.

Over a period of years, the patient had projected her own guilt feelings onto her husband, becoming extremely jealous and accusing him of extramarital relationships. When pressed, the patient admitted that she had no evidence for such accusations, and the husband denied them. Nevertheless, the patient had employed his alleged infidelity as a basis for breaking off marital relations with him. Her guilt feelings were intensified by the fact that the husband was aware of her indiscretions, but did not leave her, asserting that he was still fond enough of her to forgive her.

As the affair progressed, her difficulties with her lover increased considerably. The patient had advanced him money to use in his business. Instead of putting it to this use, the man apparently embarked on an extended trip with another woman, whom he subsequently married. In the course of time, he and his wife became the parents of a child. On the day that the patient learned of this, she attempted suicide.

PSYCHIATRIC STATUS: Basically, the patient seemed to be an emotionally immature person, dominated by feelings of inadequacy, which impelled her to fall back on chemical sedatives in an attempt to soften life's burden. The circumstances which developed with her lover caused her to feel that she had been duped for years as his mistress, and then used as a source of money with which he married another.

Inasmuch as the lover had made permanent arrangements elsewhere, the patient and her husband agreed to attempt a reconciliation. With the situation thus brought out into the open, and because it had reached a logical conclusion, the couple agreed to make the entire problem known to their family physician. The patient readily accepted the probably psychogenic origin of most of her symptoms, and felt that she could get along adequately under the management of her local physician.

DIAGNOSIS: It is the impression of the psychiatrist that this patient was suffering from a depression, situationally determined, plus a peripheral neuritis, secondary to prolonged dietary insufficiency and chronic drug ingestion.

THERAPY: At the time she was first seen, the patient had been receiving large doses of parenteral vitamins, and she was advised to continue these with her local physician. Since the disturbing situation had been altered by circumstances, it was felt that any psychotherapy directed toward permanent personality change in an individual of this age and background would not justify the time involved. If the superficial measures already employed did not succeed, she was advised to return to the clinic for hospitalization and more intensive psychotherapy. She agreed to do this, but has not been heard from in over two years.

DISCUSSION: This case is an excellent example of the way in which complex, but entirely conscious life situations can lead to profound mental and physical symptoms. Also, it shows the difficulty sometimes encountered in gaining the patient's full cooperation.

The local physician in this case was fully aware that there were psychogenic components to the case, but because of his proximity to the family, he was unable to elicit the significant psychiatric material. While there are undoubtedly many unconscious elements in this case not detected by either the family physician or the psychiatrist, the perfectly obvious conscious factors played a major role in the development of the patient's symptoms. The patient's characteristic response to emotional unrest was to develop physical symptoms, rather than to deal with the obvious discrepancies in her life situation. She found it easier to resort to drugs, directed at the temporary relief of symptoms, than to face and change the conditions actually responsible for her depression. This habit of falling back on supporting measures as a way out of unbearable situations did nothing to fortify the patient's ability to cope with future stress. However, since the patient and her husband both felt that it was desirable to pick up the fragments of their marriage, and since the suicidal attempt seemed to dissipate many of her troublesome guilt feelings, it is possible that dangerous situational stresses may not recur.

PSYCHOGENIC FACTORS IN IMPOTENCE: Impotence wounds a man's pride and hurts his feelings of self-esteem. After repeated unsuccessful attempts to perform coitus, the patient becomes justifiably apprehensive of any further attempts. This apprehension increases the likelihood of further failure and frustration. The physician can determine whether impotence is psychogenic or based on organic cause. The latter is extremely rare in men under 50. A temporary form of impotence results from emotional or physical exhaustion. The patient may use fatigue to rationalize his impotence, but this too, can be differentiated from the deep-seated inhibitions which constitute the real cause.

Some cases of impotence may be derived from anxiety over masturbation and early sexual curiosity. Guilt of this nature may lead the man to "punish himself" by impotence. Another form is found in fear of ridicule or punishment from the sexual partner. This often stems from punitive parental ridicule of childish sexual curiosity. Temporary anger or resentment toward his wife may also render a man impotent. Other causes may be fear of harming, or dread of impregnating the woman, or an unconscious unwillingness to give her full pleasure.

Some patients report an ability to perform adequately only in extramarital intercourse. Extramarital relationships, however, may not be the result of hostility. Unconscious incestuous conflicts, in which the man regards the wife as a sort of mother or sister substitute, may render the man impotent. So also may latent homosexuality or self-love. Premature ejaculation is a modified form of impotence, but usually has the same ultimate cause as impotence in general.

Many patients can be helped by kindly straightforward discussions of their problem. Some of his own emotional disturbances may not be apparent to the patient, who only knows that he is anxious or nervous. Once it is made clear to the man that his problem is not physical but emotional, and temporary, it is possible for the physician to help him seek

the underlying reasons and to offer him rational help.

Silverman, J.: Psychiatric Aspects of Sexual Disturbances. Am. J. Med. Sciences, 224:108 (July) 1952.

LONG TERM THERAPY OF ANXIETY STATES BY THE GENERAL PRACTITIONER: A recent article by Spurgeon English emphasizes that a state of anxiety in itself can be a useful emotional component of self-preservation. But too great anxiety can become an illness. Symptomatic treatments may give only short-lived results. Eventually, the underlying emotional disturbance must be removed if a real cure is to be effected.

One reason for anxiety reactions is a lack of emotional security. At least three levels in life produce this all-important security. The first is encountered in infancy and early life, represented primarily by the approval and acceptance of the mother, or mother substitute. When a small child falls, his mother picks him up and he regains his feeling of security. The physician can do the same for the adult patient. The next level stems from familiarity with and comfort gained through reassuring contacts with friends. The third level comes from personal accomplishment —increasing knowledge, gaining prestige, and achieving success.

Patients with anxiety reactions may have their first attacks somewhat dramatically. They feel as though they are "going to pieces". First, the body disturbance itself must be taken care of, both by treatment and by explaining to the patient what it means and how to cope with it. With the use of charts to illustrate how the autonomic nervous system works through its various connections in the body, it is possible to demonstrate to the patient how a charge of emotion affects his body organs and give him an acceptable explanation of his illness. Sources of childhood anxiety can be probed, as well as possible sources of guilt feelings. The physician investigates the cause of anxiety until an element of trust is established. Relief of chronic anxiety states takes time, and improvement can only be gained if the psychotherapeutic approach is consistently maintained. Fortunately, anxiety states do not usually shorten life. The patient should be reassured that although his anxiety is painful and distressing, it is not a serious menace to his health. Even this simple reassurance will go a long way toward emotional rehabilitation.

English, O. S.: Treatment and Long Term Management of Anxiety States by the General Practitioner. Med. Rec. & Annals. 46:186 (Aug.) 1952.

AGGRESSIVENESS AND TIMIDITY IN THE PRE-SCHOOL CHILD: Many parents have the false notion that the normal child is without emotional problems. Every child, of course, does have problems—the very activity of living presents conflicts and difficulties. The problem of early aggressiveness is a normal phase in the growth of a child's social activities. The act of seizing another child's toy, although not socially acceptable, is perfectly normal. The direct and primitive impulse should be guided, not squelched. Some early aggressiveness is merely curiosity—an exploration into the physical quality of the little neighbor's hair, eyes, face and toes. The child must learn gradually and with adult help that other children have feelings like his own, that they can be hurt too. When such activities increase to biting and hitting, he must be stopped gently but firmly. Handled in a gentle, down-to-earth way, in time the child will learn, when introduced into social play, that fairness and taking turns, results in mutual satisfaction.

The aggressive child needs vigorous muscular activity. He needs toys such as clay, hammer and nails, all the things that will help him to work off the excess energy he generates in daily living. Prudent management of the aggressive child may develop a dynamic leader who will make a real contribution to group life. The aggressive child may be fearful behind his bold front. This means that he, like the timid child, must be handled with friendly discipline. Both types must be made to feel that they "belong".

In contrast to the aggressive child, there is often seen a tendency to shyness in pre-school children. This is the result of growing awareness of people. Eventually, this normal withdrawal should be replaced by eagerness and curiosity to meet visitors. Another normal variety of temporary shyness in the pre-school child is a tendency to withdraw from other children. They should be allowed a natural warming-up period, after which they will learn to play and hold their own with others. Persistent timidity, however, may reflect emotional tensions.

Extreme parental attitudes may invoke and aggravate such tensions. Fear of cowardice may cause the father to push the young boy into even greater timidity. At the same time, the mother may also encourage greater timidity and dependence by an overprotective attitude. Too frequently one parent will foster aggressiveness while the other encourages timidity. This leads to confusion in the child. Positive measures for helping both the timid and the aggressive child are praise for accomplishments, supervised play, and ample opportunity for relaxed enjoyment.

Black, S.: Psychologic Aspects of Pediatrics, 41:237 (Aug.) 1952.

OLD AS HIS

THE PATIENT had "a slight stroke," her physician said. But she is only 52, and who else is there to take care of her aging father. So now what?

What, indeed, when the old become senile and the middle-aged begin to fail—perhaps even before the young are fully able to assume their own responsibilities? The years of middle life should rightfully be those of greatest peace and productivity, graced by the poise which comes with maturity and the knowledge which stems from experience. Yet, in many cases, the flow of vitality is rudely cut off, sometimes a score of years too early, it seems. "Old as his arteries," is a phrase often heard.

Arteries are not the easiest things to take care of. They cannot be exercised at will like bicepses, nor flushed out like colons, nor even reinforced like teeth, backbones, eyes and ears. One has them and one is pretty well stuck with them. When the arteries of the brain become sclerotic, the patient may develop behavior patterns which are quite foreign to his former amiable self. In some instances, the patient becomes clearly psychotic. In others, there are periods of disorientation, alternating with periods of greater lucidity. Usually, there are some signs of failing memory.

Second Most Prevalent Mental Illness in the Country

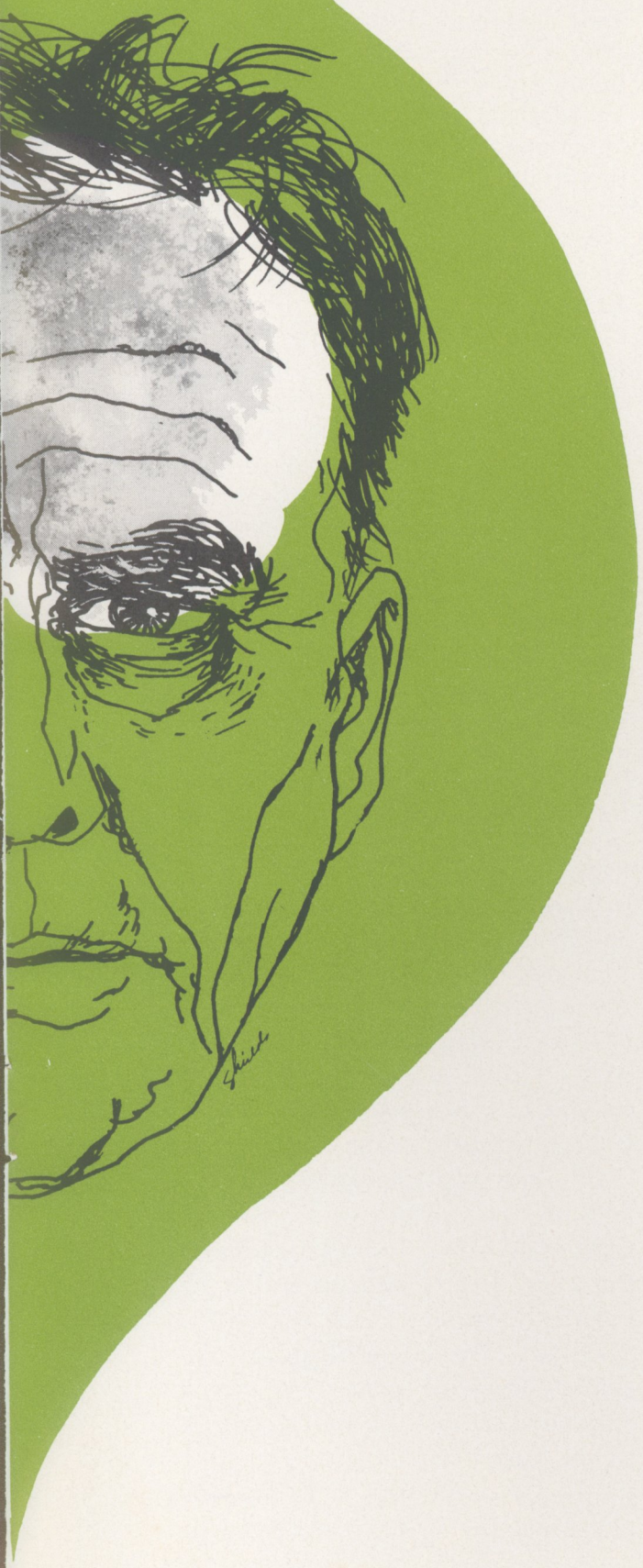
Because of its tremendous incidence, psychosis associated with arteriosclerosis is becoming one of the leading problems in psychiatry. Over a 20-year period, annual hospital admissions for this disorder have risen ten fold, until today it is estimated that patients suffering from hardening of the arteries of the brain comprise the second largest group of mentally ill, second in number only to the schizophrenics. As to the cost of this ailment, some 200 million dollars a year in public funds are spent on custodial care for its victims.

The Symptomatology Is Not Conclusive

The physical symptoms of cerebral arteriosclerosis are familiar to all physicians, as is their variability from patient to patient. The condition may be present even in the absence of any physical signs. In such cases, the history may provide sufficient evidence to suggest a minor vascular accident or two, from which the patient may have recovered almost entirely. A momentary aphasia, or temporary weakness or loss of function in one of the limbs, after which the patient regained full bodily control, may be reported. His mental and emotional equilibrium, however, often remains slightly impaired. This may be evidenced in failure to concentrate as effectively as before, or by a new and disturbing lack of resiliency in personal relationships.

In some cases, there are more obvious mental and personality changes. Intellectually, there may be a conspicuous reduction in overall capacity; judgment may fail and the memory deteriorate noticeably. The emotional life becomes dominated by lability, defensiveness and pathological suspiciousness. There may be crying without justification, or an easy transition from tears to laughter. These patients often show a growing disregard of personal grooming and social amenities, totally inconsistent with their previous personalities. As judgment recedes, there may be

ARTERIES



gradual deterioration of desirable habits into behavior quite foreign to their former natures. Also common is decreased tolerance to toxic substances, such as alcohol. Periods of confusion may occur suddenly; some patients even become victims of delusion. Thus, although the physical onset of cerebral arteriosclerosis is slow and insidious, its overt psychotic manifestations may come on without warning in the form of an acute episode.

Etiology Has Been Oversimplified

The above constellation of symptoms usually indicates the presence of some organic brain damage. For the physician to assume, however, once he notes evidence of arteriosclerosis, that *all* the patient's difficulties are directly attributable to irreversible structural change may be an oversimplification which operates to the disadvantage of the patient. The extent of physical involvement cannot be accurately estimated without careful diagnostic studies. Physical, neurologic, electroencephalographic and psychometric tests—all may prove useful in ascertaining the degree of organic change. Without convincing clinical evidence, however, it is never justified to maintain that all of the patient's mental and behavioral symptoms are of organic origin.

In cerebral arteriosclerosis, organic involvement naturally tends to be permanent. The superimposed functional stress, however, can sometimes be reversed to a considerable degree, leaving the patient greatly improved and in a much better position to carry forward his role in society. The greater the element of functional disturbance, the better prognosis may be expected for these patients, provided they receive appropriate medical and psychiatric treatment.

Since factors other than change in the vascular and nervous systems figure in the clinical picture, it becomes difficult to establish the extent of tissue damage in patients suffering from psychosis with cerebral arteriosclerosis. The intermittent manifestations of psychiatric symptoms seen in some patients may be partially accounted for by spasmodic variation in the blood supply to the brain. But other factors modify the clinical picture, for often the mental symptoms are intensified under conditions of emotional stress.

As pointed out by Rothschild, the intensity of emotional disorder is not necessarily correlated with the amount of organic damage. He and others have demonstrated through postmortem findings that gross areas of atrophy and softening may be present in the brains of patients whose history contained no evidence of mental or emotional impairment. Since so many persons die without ever developing any psychotic symptoms, yet at autopsy show these severe tissue changes, it is unfair to the arteriosclerotic patient to designate his mental disturbances as hopeless, even though they may be more or less acute.

That there is a hereditary factor at work in producing cerebral arteriosclerosis is recognized and is a further reason for some physicians to regard the disease as hopeless.

A Large Survey Is Reported

In Clow's survey of 100 patients suffering from cerebral arteriosclerosis with psychosis at the New York Hospital, 51 had a familiar history of the disease; yet *severe emotional*

precipitants, such as the death of a loved one, were noted in 76. *Drug toxicity* sufficient to produce psychotic symptoms was present in 37. The treatment of these 100 patients was both physical and psychiatric. Psychotherapy included stimulation of new interests in life, broader personal contacts, continued reassurance and occupational therapy. Under this regime it became evident that by no means were all of these cases hopeless. Eleven patients recovered, 12 were much improved, 31 improved somewhat and 46 did not improve. Following therapy, 49 were able to leave the hospital and return to their homes.

Diagnosis May Be Complicated by Other Factors

In some of these patients, an accurate diagnosis is extremely difficult to make, for the human machine does not usually deteriorate in one area alone, nor in the direction of a single disease entity. Thus, the physician sees patients with many varied combinations of the degenerating process. He sees cerebral arteriosclerotics with and cerebral arteriosclerotics without psychosis. In many different clinical conditions, an overlapping of similar psychiatric symptoms may be seen. For this reason, differential diagnosis may be impossible. Lack of an infallible diagnosis, however, does not preclude the desirability of efforts directed to improving the life situation of these individuals.

Tilkin also emphasizes that emotional conflicts coexist with minor structural altercation, and points out that each case must be evaluated on its own merits with particular attention to personality adjustment and environmental situation. "This will avoid the fallacious assumption of immutable organic changes in all the mental illnesses of persons in the older age group, and the consequent attitude of therapeutic futility."

Combined Therapy Is Preferred

Therapy can combine appropriate drugs, supervised diet and common sense. Some physicians may not have encountered the recent findings which indicate that in arteriosclerotic patients, the absorption of bromides into the spinal fluid is considerably higher than it is in normal persons, which makes possible a quicker psychotic reaction from bromide intoxication. The effects, of course, are reversible when the noxious agent is eliminated, but the mental symptoms abate slowly, sometimes requiring several weeks after the medication is discontinued.

Some physicians see no need to consider the varied ramifications when it is obvious from the history that the patient had a "little stroke", and the chances are that he will have another. Yet, there are many things such a patient can be told which can alleviate his fears and perhaps postpone the occurrence of other strokes. How many patients know that many persons have one cerebral insult and then live on in good condition for a decade or two before having another? How many laymen have ever heard of collateral circulation or other compensatory functions in which supplementary organs take up the work of damaged ones? Could not these facts carry a wealth of reassurance to the patient emerging from the effects of his first "little stroke"?

Sometimes the patient is advised to "take things easy" and to cut down on simple pleasures, such as smoking and drinking coffee. When such advice is given, the physician can easily explain to the patient the reasons these pleasures must be given up. He can point out to the patient that caffeine and nicotine in large doses are vasoconstrictors, and with weakened blood vessels such as his, overindulgence in either would be sheer folly. This knowledge alone might prevent many catastrophes. The patient then will not feel that he is being handled unjustly or arbitrarily.

Psychotherapy is directed to the removal of conflicts which may be aggravating the vascular disease. Tensions which arise as a result of the patient's awareness of his growing limitations must be dealt with. These patients are often reluctant to give up their old pursuits; if circumstances make this necessary, it is extremely important that fresh activities be substituted as compensation. It is often helpful to break up the rigid habit patterns which frequently begin to form in these individuals, by suggesting an occasional change of scene, new interests and new contacts. Finally, the physician may even have to "treat" the family, and attempt to bring about alterations in an environment which

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QUESTION: What psychiatric symptoms are caused by lesions of the temporal lobe?

ANSWER: The specific symptoms of lesions of the temporal lobe are hallucinations, perceptual illusions, automatisms, and mood disturbances. Among one hundred non-hospitalized patients with lesions of the temporal lobe studied by Mulder and Daly, fifty types of hallucinations were described. These were hallucinations of smell, taste or sound, and more complex phenomena involving vision and hearing. The perceptual illusions included the sensations of reliving a former experience, or the feeling that "I have been here before." Some patients reported distortion of size of surrounding objects. Various types of automatic activity, such as driving a car and wandering about in strange places occurred while the patients were in a state of disorientation. The mood changes included fear, dread, anger, and in some instances a feeling of well-being which appeared before an attack. The symptoms in these patients were apparently related to a paroxysmal discharge in the temporal lobe.

However, some of these patients exhibited only symptoms of emotional disorder, such as depression, anxiety, and erratic behavior. Although psychiatric symptoms were observed in all of these patients, only four had symptoms severe enough to be classified as psychotic. The lesions were localized on the basis of electroencephalograms, x-rays of the skull, ventriculograms, pneumoencephalograms, arteriograms, and surgical exploration.

Because of the prominence of mental disturbances in patients with cerebral lesions, the presence of obscure organic disease may remain undetected over a period of time. Since the symptoms of organic disease so often simulate those of emotional disorder, early search for evidence of underlying structural change is necessary for correct diagnosis and adequate treatment of patients with temporal lobe lesions.

Reference: Mulder, W. M., and Daly, D: Psychiatric Symptoms Associated with Lesions of Temporal Lobe, J. Am. M. A. 150:173 (Sept.) 1952.

QUESTION: Can the presence of unconscious mental defenses be demonstrated?

ANSWER: Psychological testing has been done to show the mind's use of unconscious defense mechanisms. One such mechanism is projection, in which the individual's own feelings are projected outward and interpreted as part of external reality. To determine factors influencing the use of projection, an experiment was conducted with a group of college students. These students were presented with two sets of pictures about which they were asked to make up stories. One set regularly evoked more aggressive stories than the other. This showed that the nature of the stimulus is important and the individual's responses are directed toward something which has a basis in reality.

The emotional state of the person is also significant. In a state of emotional tension, an individual may perceive stimuli as threatening which he would not so interpret ordinarily. This is illustrated by another part of the experiment with the students. Just before the last five pictures were shown, the experimenter paused and criticized the students sharply, saying, "You are hopeless. These are the worst stories I have ever heard." This criticism incurred resentment and hostility in the students. But instead of expressing their hostility directly toward the experimenter, they projected it into their stories. The students in a hostile frame of mind perceived the last five pictures as more aggressive than the former ones—a reaction not warranted by the content of the pictures. Thus it can be seen that subjective feelings blind a person to important motivating factors which distort his view of the world.

Reference: Bellak, L.: The Concept of Projection, Psychiatry, 7:353 (Nov.) 1944.

SPEAK

that I may see thee

Ben Jonson mixed a metaphor when he said, "Speak that I may see thee," but he showed rare insight, for he clarified his meaning when he said, "Language most *shows* a man."

The physician commonly learns more from what his patients say than the patients knowingly tell him. Psychological tests and everyday experiences reveal numerous slips of the tongue, word associations, and mental blocks, to further verify Jonson's observation.

Additional light may be thrown on the relationship of speech to emotion by a unique disorder observed in extremely young children. Noting the schizophrenic-like withdrawal of these babies still in their cribs, Dr. Leo Kanner named the disorder, *early infantile autism.*

Kanner first called attention to this phenomenon in 1943. At that time, he did not presume to classify it with the schizophrenias, nor to draw any prognostic conclusions. He merely presented as a syndrome the peculiar behavior common to all the children in this group.

By approximately the fourth month of life, the normal baby shows evidence of his developing responsiveness. He waves his arms, makes cooing sounds, and registers his delight at the prospect of being picked up. Although the concept of speech is still unformed, the normal child grasps the idea of communication. In strong contrast is the behavior of certain inaccessible little children who show no interest whatever in people.

Disorder Appears to be Emotional, Rather than Physical or Intellectual

When parents first bring such a child to the physician for examination, they often believe that the child is deaf and dumb, since they may never have heard him utter a word. After tests demonstrate that the child's hearing is unimpaired, they conclude that he must be mentally retarded. Sometimes five or six years elapse before they realize that the child is well-equipped intellectually, but deficient in a basic emotional quality—the need to relate oneself in some way to other people.

Confronted with an autistic child, a physician might first suppose that the little patient was word-deaf. This, however, is soon ruled out by the child's behavior. Aphasic children who have been psychologically studied all show a strong need for human contact. Although they cannot comprehend the sense of words, children who are word-deaf devise their own methods of communication, indicating through gestures and attitudes their extreme dependency on those who care for them. It is different with the autistic children. For, despite their apparently normal intellectual and speech faculties, they *do not use speech with intent to be understood.* They are able to talk, but apparently they have no desire to do so. One investigator has said that they have no appetite for language.

Cases have been reported in which children have remained mute for four or five years, then, under pressure of some emergency, burst forth suddenly with a complete sentence. Following this, they may say nothing more for another year or two. At least one of these so-called "mutes" was familiar with three languages.

Among those autistic children who *do* speak, there are striking language pecularities. A parrot-like repetition dominates their infrequent attempts at conversation. They tend to echo what they hear. They may repeat the exact words spoken to them, with almost identical intonation.

An obsession for literal meanings becomes apparent in their use of prepositions. They are disturbed when told that a picture is *on* the wall. Rather, it is *near* the wall or *against* it, they say. One child, when told to put something *down*, invariably placed the object on the floor.

The most frequent and persistent speech peculiarity is the substitution of the personal pronoun, "you" for "I." Many of the children are past the age of six before they cease referring to themselves as "you".

Some have been drilled in enumeration by obsessive adults and show an exceptional facility for memorizing passages by rote. An illustration is the three-year-old boy who could reel off the names of all the United States presidents and vice-presidents, and recite the catechism and 37 nursery rhymes. The fact that they do not use language with intent to communicate is shown in a little girl of five who would not talk, but who would identify aloud a musical selection such as "Scheherazade, Rimsky-Korsakoff."

The seclusive and obsessive traits revealed in the autistic child's speech pattern permeate his entire behavior. At best, the autistic child seems only to tolerate the presence of his parents, permitting his mother to dress him, and accepting what she hands him without looking into her face. Typical is the observation made by one mother: "Ordinarily he is good natured. He plays alone, humming a monotonous little tune. But if one toy is moved, he goes into a tantrum. Everything must be just so."

Unable to mingle freely with other people, the autistic child seems to derive his primary satisfaction from mastery of his own small world. Whether spinning a top or arranging his toys, the very repetition of a familiar act appears to afford him joy. It seems that his inanimate friends, the toys, receive all the affection this strange child has to bestow. He moves about in his accustomed surroundings, embracing a table leg or caressing a chair, showing them endearment such as he seldom accords his mother.

Both in speech and in behavior, stereotyped patterns are apt to be repeated, whether appropriate or not. They may have been appropriate when first used, but thereafter employed indiscriminately. When the apparent irrelevancies are traced to their source, it becomes obvious that the autistic child deals in symbols. This characteristic has long been recognized in adult schizophrenics, but the origins of *their* weird associations are often too remote and too obscure for identification.

Disorder Suggests a Restricted Form of Schizophrenia

Almost a decade has elapsed since Kanner's first description of early infantile autism. During that time, he has been in communication with many investigators whose work centers around psychiatric disorders of children. The number of cases encountered has increased from a score to approximately 100. Follow-up has been effected whenever possible, and now classification and prognosis may be attempted.

From the first, the withdrawal of the patients suggested schizophrenia, yet their behavior contained elements not found in heretofore recognized forms of schizophrenia. "The work of Dr. Kanner on infantile autism," writes Despert, "points to a need for revision of the concept of schizophrenia."

For many years it was doubted that schizophrenia actually occurred in early childhood. Nevertheless, Bleuler, as early as 1911, noted that "one can trace back the illness to childhood, or even to the first years of life, in at least five per cent of the cases." He continued, "the prognosis of those cases in which the onset of the illness occurs before puberty does not appear to be too poor for the next few years. Case histories of the adults admitted to the hospital show that at least part of these early cases relapse and then usually become markedly deteriorated."

It is of interest to compare Bleular's remarks with the only clear case of infantile autism on record in which the patient has had time to grow to adulthood.

One Adult Who Was an Autistic Child

In examining case histories prior to Kanner's, Darr and Worden encountered the case of Jane, brought to Dr. Adolph Meyer in 1921 at the age of four. Although the syndrome of early infantile autism was not to be described for 22 years, Meyer's carefully detailed report of this child places her in the same category with Dr. Kanner's group. Commenting on the case, Dr. Kanner observed: "The patient Jane has from the beginning to the present followed a course which is very much in keeping with the autistic group and very much different from other schizophrenic syndromes."

During her childhood and adolesence, Jane made a partial but inadequate adjustment to the reality of a populated world. She attended school, where she had to adapt somewhat to people, but she never seemed to develop any sensitivity to the attitudes of others. It is said that she had "a princess air" and made unreasonable demands on people, becoming angry when they failed to comply. At the age of 32, following a separation from her mother, she became overtly psychotic.

The first question which Dr. Kanner raised was whether a different kind of therapy might have prevented the development of Jane's psychosis. Commenting on his own group of autistic children, he said, "the majority of the autistic children have settled in their withdrawal to the extent that no emergence seems possible."

Etiology Must Determine Therapy and Prevention

If it is not amenable to cure, the next question of importance in any disorder is whether subsequent cases might possibly be prevented. The outlook for the prevention of infantile autism is based on the correction of etiological factors. Usually, when one assembles 100 cases of any disease, the etiological picture is likely to become complicated by a variety of different influences. The case reports of these autistic children, however, contained one rather astonishing common denominator. All of them came from highly intelligent and efficient parents, most of whom were engaged in technical or professional pursuits. Many of the fathers are listed in *Who's Who* or in *American Men of Science.* The mothers, too, are extremely well educated and many of them have been engaged in artistic or scientific professions.

As an outstanding characteristic of most of these parents, Kanner points out "a mechanization of human relations". Serious and undemonstrative, they seem to prefer books to people, and are typically cool and abstract in their own interpersonal relations. No passion or turbulence is complained of in their marriages; their record of divorce is almost nil, and they give no indication of disrupting extramarital affairs. Kanner states: "My search for autistic children of unsophisticated parents has remained unsuccessful to date." The detachment of the parents of autistic children is unique. Although scientific and efficient with regard to the child's regime, they seem totally lacking in warmth and spontaneity toward the child. The obsessiveness with which some of the parents train the children to recite tedious and incomprehensible passages suggests that they look on children as if they were highly perfected mechanical dolls.

There is little wonder that a child so regarded never gets the idea that he is a person in a world of other persons. Without fully developing a sense of self and relatedness to others, they are unable to cope with the give and take of human existence. In the words of Darr and Worden with reference to Jane, "The patient's difficulty in experiencing herself as a human being is in no way different from the mother's difficulty in perceiving her as a human being. One wonders if in the very early months of life this patient gave up a fruitless emotional investment in the mother, and has never reinvested in subsequent persons."

Kanner described as typical the attitude of one mother who brought her child to the clinic. She went ahead resolutely, letting the child drag forlornly behind her. She ignored the child completely in the waiting room. In the interview, when asked to take the child onto her lap, she did so, but held it away from her body, balancing it stiffly like a dummy.

Fathers often display the same detached aloofness. One father is mentioned who could present in minute detail the child's statistical record. In an effort to ruffle his impassive facade, Dr. Kanner asked this father whether he would recognize his own children in the street. "Far from being irked," reports Kanner, "he deliberated for a while and replied just as impassively that he was not sure he would."

Because of the consistency with which parents of autistic children display cool and mechanistic detachment toward the children, it is felt that this factor may be of etiological significance in the development of the disorder. Careful search for evidence of organic involvement in these children has been unproductive. Also, inquiry into the hereditary background shows a surprising lack of psychotic antecedents. The attitudes and behavior of the parents, therefore, assume an even greater importance as a possible causative factor. It may be that as these parents become engrossed in

their various professions, their own need for warmth and tenderness recedes, and the desire for children as part of their life's fulfillment becomes superfluous.

Two avenues of hope may be open to the parents of an autistic child, provided the syndrome is recognized sufficiently early. One is to attempt reversal of the environmental picture by removing the child to an utterly contrasting type of home, with foster parents who are emotional, impulsive, and unrestrainedly loving. The other involves reorganization of the emotional make-up of the actual parents, which sometimes may be affected through psychotherapy. Either course demands personal sacrifice on the part of extremely rigid adults. Their superior intellectual endowments, however, might enable some of them to accept an otherwise unwanted course in the hope of preventing irreparable damage to the young lives they engendered.

Fortunately, the number of autistic children is small. Indeed, as a clinical problem, it is rarely encountered. Nevertheless, it poses significant questions as to the role of parental rejection in the emotional development of all types of children. If gross deprivation of warmth and affection is primarily responsible for autistic withdrawal, cannot lesser deprivation also injure children to a lesser degree? Is it possible that some children have a higher threshold to rejection than do others? Or does the clue to the disorder lie in the particular *type of rejection* to which the the autistic children are exposed?

At times, all parents feel rejecting toward their children. This is natural and inevitable. It cannot do much harm, provided the children know that beneath the transient episode of parental rejection their parents love them, and that *this basic and abiding love will not waver, whatever happens.* Proof that sudden or even violent flights of animosity leave children undismayed is found in the way that children tease a busy or preoccupied parent. They goad their parents into irritation, or even to fury, if need be, to obtain for themselves a little attention. This is not an unhealthy sign on the part of the child. He merely prefers to be screamed at than to be ignored. It would seem that rejection must be basic, absolute and constant in order to inhibit the development of any outgoing impulse toward others.

Nothing living is so full of promise, hope, and potential responsiveness as is the human infant. But even he can be effectively discouraged, like the tendrils of a vine, which reach out to emptiness, and then recoil, desiccate, and die.

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THE PERSECUTED

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workings of his body is expressing delusions of persecution. The physician is often the first to whom these sentiments are voiced. Other patients may confide that they are marked for high destiny when obviously they are ill equipped for such a role.

Some authorities believe that repressed homosexual desires figure in paranoid conditions. This theory receives further impetus from the fact that certain paranoid individuals are unduly preoccupied with their own rectal or genital areas. This concern may mask deviant sexual yearnings. Although such patients complain of discomfort in those areas, examinations or operations on the parts may be interpreted as sexual assaults. Another group of potentially dangerous patients are those in whom strong paranoid ideas are unmasked by alcohol or drugs.

When the patient's life situation offers satisfaction and security, his dangerous tendencies may remain dormant. But anything which diminishes his security and self-esteem may precipitate a dangerous situation. The patient may show exaggerated ideas that everything refers to himself. Other danger signals are misinterpretation of a commonplace event, and narrowing of the focus of hostility to one or two persons. Invariably, when the subject of his delusion arises, the patient will "protest too much." Such signs as unwarranted agitation, or a strained, insistent voice betray the increasing pressure of the ideas. The physician must recognize the hazard and be prepared to deal with these patients firmly, honestly and effectively. Should he decide for good medical reasons that he cannot help the patient further, he should be extremely cautious in withdrawing his support. The physician who recognizes the significance of paranoid symptoms will try to provide adequate psychiatric assistance for these patients before the projective mechanism escapes the bounds of ideas and is translated into action.

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OLD AS HIS ARTERIES

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can only make the patient's situation worse. Relatives may be advised that attentiveness which makes the patient feel important is valuable in restoring feelings of security. Any such measures will be worthwhile.

Forced retirement often carries a terrific loss of self-esteem. If the patient's abilities are directed into other vocational channels—by making advance plans for retirement—he may be spared the enormity of dismissal because of age. In many of these matters, the physician is frequently consulted. He is in the position to offer real hope to one whose outlook would otherwise be fairly hopeless.

When one considers the huge toll in numbers of persons incapacitated by cerebral arteriosclerosis, it is obvious that reclamation of even ten per cent of them would salvage a huge segment of suffering humanity.

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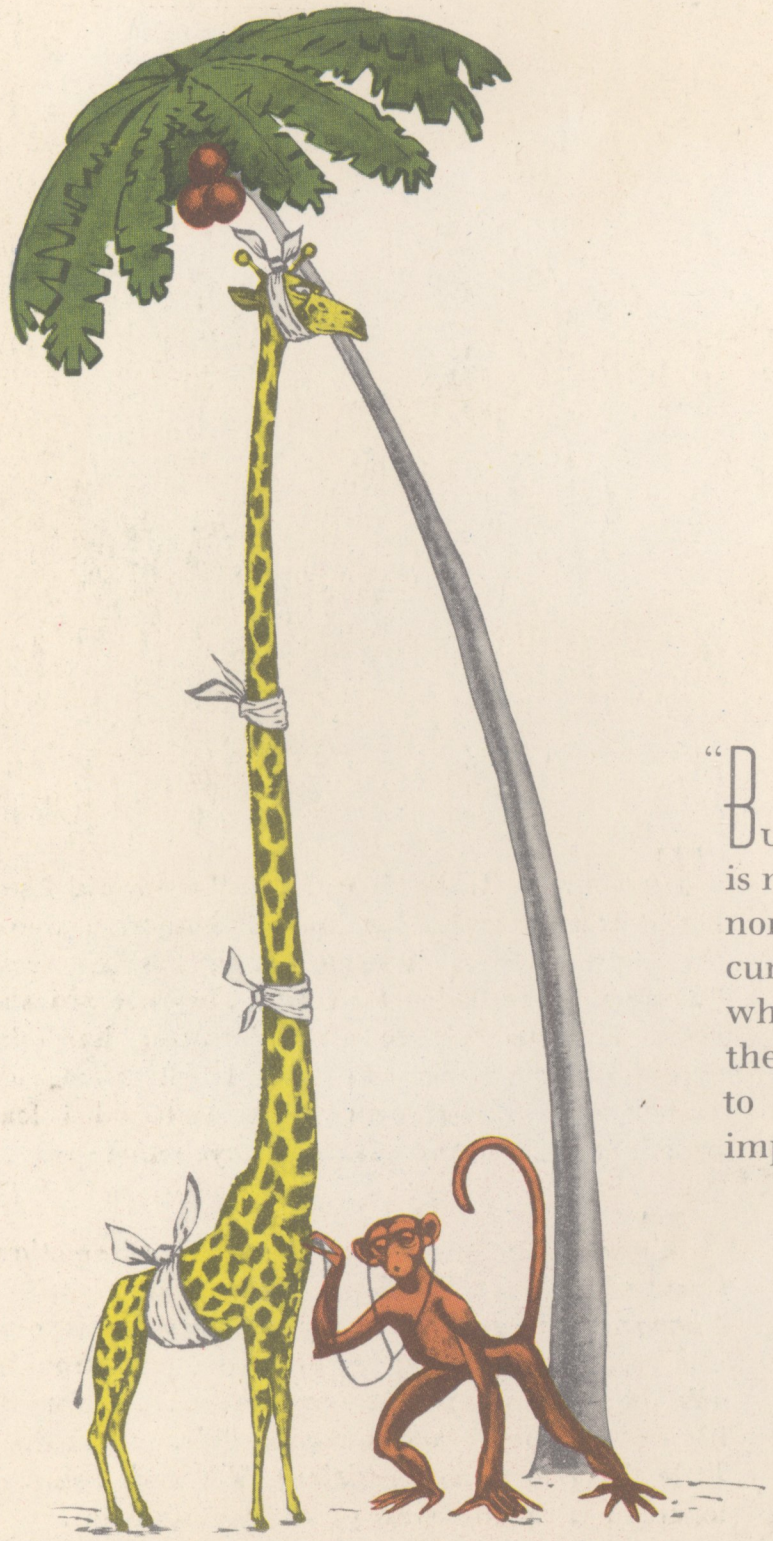
FEAR

THE KILTED "Ladies from Hades" are world-famed for their courage in the face of danger. Yet even the stalwart Scots have a proverb which reads, "There is no medicine for fear". They are probably right. The medical profession, however, has other means of ministering to fearful patients. Many persons who suffer from vague, unfounded fears benefit greatly from adequate psychotherapy.

FEAR is but one of many sources of emotional stress which takes insidious toll on many patients. Supportive therapy, so easy to provide, is often underestimated. Listening to a patient's troubles, offering such reassurance as is feasible, bolstering his self-confidence whenever possible, may seem a little thing to some physicians. Yet such measures loom large in the welfare of most patients.



"But our King Zalmoxis, being a god, says that, as it is not proper to attempt to cure the eyes without the head, nor the head without the body, so neither is it proper to cure the body without the psyche; and this is the reason why many diseases escape the Greek physicians, because they are ignorant of the whole, to which attention ought to be paid; for when this is not in a good state, it is impossible for a part to be well."

Dialogue Charmides, PLATO